**INITIAL MEDICAL HISTORY - RAVALLI COUNTY FAMILY PLANNING**

**In order to provide you with the best medical care, we must have a complete history. Please complete this form as accurately as possible. All information on this form is held strictly confidential.**

Name: _____
(Last) (First) (Middle)

REASON FOR TODAY'S CLINIC VISIT: _____

Have you had a pelvic exam? ___ NO ___ YES If YES, date of last pap/exam _____ Dr. _____
Have you been instructed in self breast exam? ___ NO ___ YES Do you do self breast exams? ___ NO ___ YES ___ SOMETIMES

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? **(CHECK IF YES)**

_____ Epilepsy/convulsions
_____ Stroke
_____ Severe Frequent Headaches
_____ Dizziness/Fainting Spells
_____ Blurred Vision/Eye Problems
_____ Thyroid Problems
_____ Heart Attack
_____ Heart Murmur
_____ Rheumatic Fever
_____ Other Heart Disease
_____ Breast Mass/Lump
_____ Breast Discharge
_____ Breast Cancer
_____ Other Breast Disease/Surgery
_____ Asthma
_____ Liver Disease (mono, hepatitis)
_____ Gallbladder Disease
_____ Kidney/Urinary Tract Infections
_____ Stomach/Bowel Problems
_____ Endometriosis

_____ Uterine Abnormalities
_____ Uterine Cancer
_____ Ovarian Cyst
_____ Unusually Painful Periods
_____ Unusual/Escessive Vaginal Discharge
_____ Pain With Intercourse
_____ Bleeding After Intercourse
_____ Gonorrhea
_____ Chlamydia
_____ Venereal Warts
_____ Herpes
_____ Pelvic Infection (PID)
_____ Other sexually Trans. Disease
If so, what? _____
_____ Anemia
_____ Blood Clots
_____ High Cholesterol Levels
_____ High Blood Pressure

_____ Cancer
_____ Diabetes
_____ Severe Emotional Problems (e.g. Depression)
_____ Genetic Conditions
_____ Weight Problems
_____ Sensory Problems (e.g. numbness)
_____ Varicose Veins
_____ Tuberculosis
_____ Abnormal Pap Smear
_____ Have You Had Rubella (German Measles) or Been Immunized?
_____Blood Transfusions
_____Hepatitis B Virus
_____Acne
Did Your Mother Take DES During Pregnancy? (DES is a hormone some women were given during pregnancy to prevent miscarriage.) ___ Yes ___ No ___ Unsure

LIST ANY SURGERIES, HOSPITALIZATIONS (EXCEPT PREGNANCY), OR OTHER SERIOUS ILLNESS NOT MENTIONED ABOVE: _____

**DRUGS AND MEDICATIONS:** What medications (prescription, non-prescription, and "street" drugs) are you currently taking?
MEDICATIONS: _____
Do you have any Medication Allergies? _____ Name: _____ Any other Allergies? _____
Do you use alcohol? _____ NO _____ YES (if YES, how often?) _____
Do you use tobacco? _____ NO _____ YES (if YES, how many packs per day?) _____
Have you EVER shared needles or injection equipment with another person for any reason? _____ NO _____YES

**SEXUAL HISTORY:**
Have you ever had sexual intercourse? _____ NO _____ YES (If YES, at what age did you become sexually active?) _____
Have you had sex with: **(please circle)** Men Women Men and Women
If you have a sexual partner, does that person have now or have a history of: (Check if YES)
_____ STD's _____ Penile Lesions _____ Penile discharge _____ Painful Urination
Have you ever felt that a sex partner put you at risk for any reason? _____ NO _____ YES
Number of sexual partners in the past year? _____
Have you had a new sexual partner in the past three months? _____ NO _____ YES
What do you do to protect yourself from AIDS? _____
Do you have any behaviors you would like to change or think you should change? _____
Have you ever been talked into or forced to have sexual contact? _____ NO _____ YES
Do you wish to discuss this with someone? _____ NO _____ YES
**(OVER)**

**FAMILY HISTORY:** _____ I cannot answer the following because I was adopted.
Please check if any parents, brothers, or sisters have or have had any of the following:

| | | |
|---|---|---|
| ___ Cancer | ___ Stroke _____Age | FOR OFFICE USE: |
| ___ Diabetes | ___ Birth Defects | Bloodwork |
| ___ Heart Attack _____Age | ___ High Blood Pressure | _____ Discussed |
| ___ High Cholesterol Levels | ___ Any Hereditary Disease | |

**MENSTRUAL HISTORY:**
Have you had: ___ Bleeding since last period ___ Bleeding between periods ___ Missed periods
Age when periods started: _____ First day of last normal period: _____

| YOUR MENSTRUAL CYCLE: (When not taking Birth Control Pills) | | | | |
|---|---|---|---|---|
| Number of Days Between Periods (1st day of one period to 1st day of next period) | Number of days period lasts | Number of pads/tampons used on heaviest day | Are your cycles: _____ Regular _____ Irregular | _____ Bad cramps (Medications: _____) _____ Premenstrual Tension |

Birth Control Method you are now using: _____ Any problems? _____
Do you want to have children in the future? ___ NO ___ YES ___ UNSURE
Have you had intercourse without using birth control since your last period? ___ NO ___ YES

| PLEASE LIST ALL BIRTH CONTROL METHODS YOU'VE USED IN THE PAST | | | | | | |
|---|---|---|---|---|---|---|
| Method | Date Started | Date Stopped | Problems with Method/ Reason Stopped | Used Method: ALWAYS | SOMETIMES | SELDOM |
| | | | | | | |
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**PREGNANCY HISTORY:**
Have you ever been pregnant: ___NO ___ YES Age at First Pregnancy: _____
Number of living children: _____ Total number of pregnancies _____ Genetic conditions/abnormalities: _____

| Date Pregnancy Ended | PREGNANCY OUTCOME (check one) | | | | | Method of birth (e.g. C-section or Vaginal) | Complications of pregnancy |
|---|---|---|---|---|---|---|---|
| | Miscarriage | Still Birth | Abortion | Live Birth | IF BIRTH: Baby's Weight | | |
| | | | | | | | |
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Are you currently breast feeding? ___ NO ___ YES
Is there anything else we should know about you? _____ Do you have any questions or concerns regarding your medical care?

**Please Sign Here:** _____ **Date:** _____

OFFICE USE ONLY: Reviewed with Patient _____

Signature and Title: _____ Date: _____